ROCKFORD SCHOOL
Student Registration

DATE _____ GRADE ___ BOY __ GIRL __

BIRTHDATE _____

PUPIL'S NAME _____ PLACE OF BIRTH /Optional _____

ADDRESS _____ P.O. BOX _____ Home Phone _____

_____
City Zip

LAST SCHOOL
ATTENDEND _____ ADDRESS _____

PARENTS/GUARDIANS (**LIVING IN HOME**)

NAME _____ RELATIONSHIP _____
Place of employment _____
On Active Duty with Armed Forces or Full time duty with National Guard: Yes _____ No_____

1ST Primary Contact Cell Phone # _____ **Would you like to receive Text messages? Yes ___ No ___**

NAME _____ RELATIONSHIP _____
Place of employment _____
On Active Duty with Armed Forces or Full time duty with National Guard: Yes ____ No ____

2nd Primary Contact Cell Phone #_____ **Would you like to receive Text Messages? Yes ___ No ____**

LIST OF CHILDREN (**LIVING IN HOME**)

Names	DOB
_____	_____
_____	_____
_____	_____
_____	_____

Office use only:
Teacher/Class ____
Immunizations Complete ____
Need follow up ____
Birth Certificate ____
Cheryl ___ Diana ___

ACTIVITY PERMIT:
I hereby grant permission for my child to attend any activity, which will be under supervision of and subject to the jurisdiction of the school district.

	YES	NO
FIELD TRIPS	___	___
AFTER SCHOOL ACTIVITIES (GRADES 5-8)	___	___
OTHER SCHOOL SPONSORED ACTIVITIES	___	___
PHOTO RELEASE FOR: (School activities, school website, yearbook, SARB)	___	___

INSURANCE: All students who participate in the school athletics program MUST have accident insurance. Parents may buy school insurance for their child. Contact the school office for details. Do you have personal accident insurance or medical card for your child?
YES ___ NO ___

Do you have Medi-Cal for your child? YES___ NO ___

List any health problems or difficulties your child has which may affect his work at school:

_____

List any current medications:

_____

Does your child receive Special Education services? YES___ NO___

Signature of Parent/Guardian _____

ROCKFORD SCHOOL – EMERGENCY CARD

NAME _____ _____ _____
(Print) Last (legal) First Middle (name) Age Birth date

STUDENT LIVES AT _____
(Print) Apt. # Zip Code

SEX: M F _____/_____/ _____
(Circle) Cell Phone# FATHER Cell Phone# MOTHER HOME PHONE #

FATHER _____ _____ _____
(Print) FULL NAME (Circle Yes/No-Lives with pupil?) Employer/Occupation Work Phone #

MOTHER _____ _____ _____
(Print) FULL NAME (Circle Yes/No-Lives with pupil?) Employer/Occupation Work Phone #

OTHER _____ _____ _____
(LEGAL STEP/FOSTER/GUARDIAN) Employer/Occupation Work Phone #

SERIOUS HEALTH PROBLEMS: (CIRCLE)
Bee Sting Reaction / Hearing / Allergies
Convulsions / Vision / Diabetic / Orthopedic
Asthma / Cardiac Condition

***If Child Is on Medication at School, A Pupil Medication Form must be on file.

_____
NAME OF MEDICATION

PLEASE EXPLAIN ANY CONCERNS _____

IN CASE OF AN EMERGENCY OR IF PARENT / GUARDIAN ARE NOT AVAILABLE, CALL THE FOLLOWING:

NAME	RELATIONSHIP	PHONE #
NAME	RELATIONSHIP	PHONE #
NAME	RELATIONSHIP	PHONE #
NAME	RELATIONSHIP	PHONE #

In case of an accident, and a parent cannot be reached, I wish my child to be placed under the emergency care of:

Doctor's Name: _____ Phone: _____

AUTHORIZATION OF CONSENT TO TREATMENT OF MINOR

I (We), the undersigned, parent(s) or legal guardian(s) of _____ a Minor, do hereby authorize the ROCKFORD SCHOOL DISTRICT, as agent for the undersigned to consent to any treatment deemed advisable by, and to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of Sierra View District Hospital.

It is understood that this authorization is given in advance in case of an illness or injury occurring at school with the school authorities being unable to reach the undersigned parent(s) or guardian(s).

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

_____ _____ _____ _____
MOTHER/LEGAL GUARDIAN' S SIGNATURE DATE FATHER/LEGAL GUARDIAN'S SIGNATURE DATE

STUDENT INFORMATION FOR CAASPP TESTING

Student Name_____ **Date** _____

Grade _____ **Date of Birth** _____ **Sex** _____

ETHNICITY

Mark the ethnicity with which the student most closely identifies.

☐ Hispanic/Latino – A Person of Cuban, Mexican, Puerto Rican, South Or Central American, or other Spanish culture or origin, regardless of race.

☐ Not Hispanic/Latino

PRIMARY RACE

Mark the race with which the student most closely Identifies.

☐ **American Indian or Alaskan Native –** A person having origins in any of the Original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

ASIAN- A Person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent.

☐ Chinese ☐ Japanese ☐ Vietnamese ☐ Laotian ☐ Hmong

☐ Korean ☐ Asian Indian ☐ Cambodian ☐ Other Asian

PACIFIC ISLANDER- A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ Hawaiian ☐ Samoan ☐ Guamanian ☐ Tahitian ☐ Other Pacific Islander

☐ **Filipino-** A person having origins in any of the original peoples of the Philippine Islands.

☐ **Black or African American** – A Person having origins in any of the black racial groups of Africa.

☐ **White-** A person having origins in any of the original people of Europe, Middle East, or North Africa.

SECONDARY RACE

Mark any additional race with which the student most closely identifies

☐ **American Indian or Alaskan Native –** A person having origins in any of the Original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

ASIAN- A Person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent.

☐ Chinese ☐ Japanese ☐ Vietnamese ☐ Laotian ☐ Hmong

☐ Korean ☐ Asian Indian ☐ Cambodian ☐ Other Asian

PACIFIC ISLANDER- A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ Hawaiian ☐ Samoan ☐ Guamanian ☐ Tahitian ☐ Other Pacific Islander

☐ **Filipino-** A person having origins in any of the original peoples of the Philippine Islands.

☐ **Black or African American** – A Person having origins in any of the black racial groups of Africa.

☐ **White-** A person having origins in any of the original people of Europe, Middle East, or North Africa.

PARENT EDUCATION LEVEL

Check the response that describes the education level of the most educated parent.

☐ Not a high school graduate

☐ High school graduate

☐ Some college (includes AA degree)

☐ College Graduate

☐ Graduate school/post graduate training.

☐ Declined to state or unknown

ROCKFORD SCHOOL DISTRICT

HOME LANGUAGE SURVEY

_____ _____

DATE TEACHER

The California Education Code requires schools to determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students.

Your cooperation in helping us meet this important requirement is requested. Please answer the following questions and return this form to the school. Thank you for your help.

Name of student: _____ _____ _____

LAST FIRST MIDDLE GRADE AGE

1. Which language did your son or daughter learn when he or she first began to talk? _____
2. What language does your son or daughter most frequently use at home? _____
3. What language do you use most frequently to speak to your son or daughter? _____
4. Name the language most often spoken by the adults at home: _____

_____

Signature of Parent of Guardian

ROCKFORD SCHOOL

HEALTH HISTORY FORM

Child's Full Name: _____
Last First Middle

Male _____ Female _____ Birth Date _____

Health Conditons: Please check any of the following that your child currently has or has had in the past.

____ Abnormal Spine Curvature (Scoliosis, etc.)
____ADD/ADHD
____Allergies or Hayfever
____Anemia
____Arthritis
____Asthma/Wheezing
____Behavior Problems
____Birth/Congenital Malformation
____Cancer, Type _____
____Chickenpox, Date: _____
____Chronic Diarrhea or Constipation
____Diabetes
____Eczema
____Frequent Headaches
____Frequent sore throat/infections
____Heart Disease, type _____
_____Hepatitis
_____Kidney Disease, type_____
_____Measles
_____Migraine Headaches
_____Mumps
_____Nervous twitches/tics
_____Seizures or Epilepsy
_____Toothaches
_____Tuberculosis (TB)
_____Depression
_____Urinary Tract Infection
_____Urinary accidents (night/day)
_____Other Chronic Health Problem

Explain checked items: _____

_____

Any condition that would prevent full participation in educational programs (including physical education) requires physician documentation/orders before modifications can be considered. *See your School Nurse for further information.*

Allergies: Please list and describe allergies/reactions to:

Medications/Drugs_____Treatment_____
Foods/Plants/Animals/Other _____ Treatment_____
Bee Stings/Insect Bites _____Treatment_____

IF YOUR CHILD REQUIRES MEDICATION FOR TREATMENT OF AN ALLERGIC REACTION DURING THE SCHOOL DAY, SEE YOUR SCHOOL NURSE FOR FURTHER INFORMATION.

Injuries and Illnesses- Please list any severe injuries or illnesses:

Illness/Injury	Date(s)	Hospitalized
_____		Yes/No
_____		Yes/No

Vision and Hearing (Check all that apply)

____Frequent Ear infections (3 or more per year)
____Hearing Loss Circle one- Right/Left/Both
____P.E. Tubes (Date placed _____. Still in place? Yes/No)
Last Hearing Exam _____

_____Vision Problems
_____Wears Glasses/Contacts (Circle One) Reason _____
Last Vision Exam: _____

ADDITIONAL INFORMATION:

Does your child see the doctor regularly for a chronic medical condition? (Circle One) Yes / No
If yes, please complete the following.
What is the medical condition? _____
Doctor's Name: _____Phone: _____
What medications are given daily? _____
What medications are given frequently, but not daily? _____
When did your child last see the doctor for this condition? _____

IF YOUR CHILD REQUIRES MEDICATION DURING SCHOOL HOURS (Prescription or over the counter), SEE YOUR SCHOOL NURSE. CERTAIN FORMS MUST BE COMPLETED FOR MEDICATION TO BE DISPENSED DURING SCHOOL HOURS.
Doctor's name: _____Phone:_____
Dentist's name: _____Phone: _____
Date of last physical exam?_____ Date of last dental exam?_____
Do you have any concerns about how your child gets along with other children?
_____
Do you have any comments or concerns about this child's health, behavior, family or home life that your would like the school to be aware of? If yes, explain briefly:
_____

HAS YOUR CHILD EVER BEEN EVALUATED FOR:
_____SPEECH/LANGUAGE IMPARIMENT
_____OT/PT (Occupational or Physical Therapy)
_____LD/SLD (Learning Disability/Specific Learning Disability)
_____CD (Cognitive Disability)
_____MD (Multiple Disabilities)
_____ED (Emotional Disturbance)

Other household members:

Name: _____Relationship _____Age _____
Name _____Relationship _____Age _____
Name_____Relationship_____Age_____
Name_____Relationship_____Age_____
Name_____Relationship_____Age_____

Form Completed by: _____
Relationship to child: _____

I (do/do not) give my permission for the SCHOOL NURSE to share this information as needed for the benefit of my child's health and educational needs, except for:_____
_____.

_____Date_____Phone_____
Signature

ROCKFORD SCHOOL DISTRICT

NOTICE TO PARENTS AND GUARDIANS

As required by law, you are hereby notified that you have a right to permit or to refuse to permit your child to engage in the school activities listed below. **THE ONLY PROGRAMS PRESENTLY PLANNED TO BEGIN THIS SCHOOL YEAR ARE STARRED (*).**

1. Absence for religious purposes at a place away from school property and after the pupil has attended school for a minimum day.

2. Sex education courses for family life education in which reproductive organs and their functions are described, illustrated or discussed. If such a course is planned at some future time you will be notified of your rights to inspect and review pertinent written or audiovisual materials prior to the holding of the course. (Written consent is not required, but written objection shall be honored for your child.) This section does not apply to words or pictures in any science, hygiene or health textbook. A teaching credential may be revoked for violation. (E.C. 8506).

3. Venereal disease education rules are similar to those in Item 2 above. (E.C. 8507).

4. Excuse from instruction in the areas covered in Items 2 and 3 due to religious beliefs (including personal/moral convictions) of the parent shall, upon written request, be permitted for the parts in conflict with the beliefs. (E.C. 8701).

5. Immunizations for communicable disease may be consented to in writing by a parent for a licensed physician to administer an immunizing agent.

***6. Administration of medication prescribed by aphysician for a child during the school day may be done by a nurse, secretary, or teacher if designated, under detailed doctor;s instructions, but only upon written parental request. (E.C. 11753.1).**

***7. Physical examination may not be given to a child whose parent has filed an objection for the year. However, the child may be sent home if, for good reason, he is believed to be suffering from a recognized contagious or infectious disease.**

***8. Evaluation of vision on a child, including tests for visual acuity and color vision by the school nurse, or teacher if authorized, upon first enrollment and at least every third year thereafter. The evaluation may be waived upon presentation of an appropriate certificate from a physician or optometrist.**

***9. Medical and hospital services for pupils injured at school-sponsored events or while being transported may be insured at district or parent expense.**

PARENTAL: CONSENT OR OBJECTION

I hereby consent for the current year to each starred item, except that I object to items _____.
(Leave blank OR write in the number of each starred item, if any, to which you object). Disregard non=starred items because you will receive further notice if any such item is later planned to occur this year.

Name of Student:_____Grade:___ Signature of Parent:_____
date

ROCKFORD SCHOOL DISTRICT

TO: PARENTS OF ROCKFORD SCHOOL STUDENTS

RE: PARENT VOLUNTEERS

We would like to give you the opportunity to be a part of your child's education by offering to help in some voluntary capacity. If you would like to be involved in this way, please fill out the following form and return it to school.

STUDENT'S NAME: _____ **TEACHER:** _____

PARENT'S NAME: _____ **PHONE #** _____

_____**Yes, I am interested in being a parent volunteer at my child's school.**

I MAY BE INTERESTED IN:

_____ **Being a room parent for my child's classroom.**

_____**Help by providing punch, cookies, etc. for class parties.**

_____**Accompanying my child's class on a field trip. (be a chaperone).**

_____Helping with a special event:
- ___Halloween Fun Night
- ___Bring a cake for the cake walk
- ___Help serve food for the Parent Group
- ___Book Faire
- ___Spring Chicken Dinner (1st Sunday in May)

____Providing classroom help with Math, Reading, etc. (Tutoring)

____Volunteering art demonstrations (share an art acitivity or craft)

____Provide bilingual help (work with students in another language:
Please state the language: _____

____Volunteering to share your experience:
- ____ Have you ever lived or visited another country?
- ____Do you speak other languages other than English?

Day or Days you would be available:
___Monday ___Tuesday ___Wednesday ___Thursday ___Friday ___

Hours I am available: (Teacher's hours may vary)
___8:30 – 9:30 ___9:30-10:30 ___ 10:30-11:00 ___1:00-1:30 ___1:30-2:00

Grade(s) I would be interested in helping in: K 1 2 3 4 5 6 7 8 (circle)

Skills I could offer to the school:
___Typing, Filing ___Grading papers ___ Work with small groups ___Computer instruction
___Work with individual students

District Philosophy:
We appreciate and encourage parental support and involvement at Rockford School. We feel it is important that all parent volunteers work closely with the classroom teacher for directions and guidance regarding the scheduling of all school activities and functions. We pledge to continue to work to the best of our abilities to provide the most excellent learning environment possible.

In order to comply with the Education and Penal Codes of the State of California, all parent volunteers are asked to report to the school office prior to going into the classrooms. Thank you for your cooperation with these regulations.

Parent Signature:_____Date:_____

ROCKFORD SCHOOL DISTRICT

THE TEACHER PLEDGE:

I understand the importance of the school experience to every student and my role as a teacher and model. Therefore, I agree to carry out the following responsibilities to the best of my ability:

_____ I will teach all the necessary concepts to your child before regular homework is assigned.

_____ I will strive to be aware of the individual needs of your child.

_____ I will regularly communicate with you regarding your child's progress.

Teacher's Signature _____ Date _____

THE STUDENT PLEDGE:

I realize that my education is important to me. It helps me develop tools I need to become a happy and productive person. I also understand my parent(s) want to help me do my very best in school. I know I am the one responsible for my own success, and that I must work hard to achieve it. Therefore,

I agree to carry out the following responsibilities to the best of my ability:

_____ I will return completed homework on time.

_____ I will return corrected work to my parent(s).

_____ I will arrive at class on time every day unless I am ill.

_____ I will be responsible for my own behavior.

_____ I will strive to be a good learner.

_____ I will be respectful to the school staff, school property and my fellow students.

Student's Signature _____ Date _____

THE PARENT PLEDGE:

I realize that my child's educational years are very important, and I understand that my participation in my child's education will help his or her achievement and attitude. Therefore, I agree to carry out the following responsibilities to the best of my ability:

_____ I will provide a quiet place for my child to study.

_____ I will encourage my child to complete his/her homework.

_____ I will make sure my child gets an adequate night's sleep.

_____ I will see that my child arrives at school on time every day.

_____ I will encourage my child to read at home on a daily basis.

_____ I will attend Back-to-School Night and Parent Conference.

Parent's Signature _____ Date _____

Rockford School
Fax Number- 784-8608

Medication in School Procedure

Dear Parents/Guardians,

Rockford School extends you the courtesy of giving your child the necessary medications during school hours. However, for your child's health and safety, we can assist with administration of medication **only** if the following procedure is followed.

Medication Procedure: (All must be completed)

1. Pick up medication form from the school office to be completed by the parent and doctor. (At beginning of each school year, a new form must be completed).
2. The form should be completed by the student's physician detailing the method and time schedules for taking the medication.
3. Medication must be brought to school in the original prescription bottle by parent or guardian.

Facts You Should Know:

1. **A note from home is not enough.** A medication form **must** be completed by physician and parent.
2. Medication brought to school by the child, even with a note, **cannot be given at school.**
3. Tylenol®, cough drops, ointments, cold pills, eye drops, asthma inhalers, etc. are all medications. This medication procedure must be followed with these as well.

By law, no exceptions can be made to these rules. If they are not followed, we cannot assist with administering your child's medication at school. You must then come to the school and administer the medication to your child.

Thank you for your understanding and cooperation in this matter. If you have any questions, please do not hesitate to call: Mrs. Hicks at 784-5406.

ROCKFORD SCHOOL
FAX NUMBER: 559-784-8608

MEDICATION IN SCHOOL

California Education Code 49423 states that medication may be given at school, when absolutely necessary for adequate treatment of the child, with the following provisions:

1. A request in writing signed by the parent.
2. An order in writing from the physician giving instructions for medication - the type, dosage, and method of administration. Time limit must be stated, such as: order effective 3 mos., 6 mos., etc.
3. Medication must be clearly labeled and in the original and current prescription container.
4. Form is only valid for the current school year.

In January, 2005 a new California Law (AB2132) adds the following requirements for ASTHMA Medication:

1. If checked below, the following signature by the parent and physician gives consent for the student to self-administer his/her asthma medication
2. If checked below, the following signatures gives a release to absolve the school district and school personnel from civil liability if the self-administering student suffers an adverse reaction.
3. The parent signature is a release that allows the school nurse or other designated school personnel to consult with the student's physician if questions or concerns arise.

PHYSICIAN PLEASE COMPLETE FOR ASTHMA MEDS:

□***This is a confirmation that this child is to carry and administer his/her asthma medication***

□***This child is to have assistance with his/her asthma medication***

PLEASE COMPLETE FOR ALL MEDICATIONS:

Medication is absolutely necessary at school for the following reason:_____

_____

Possible Side Effects of Concern: _____

_____

School:	Address:	Phone:	FAX:
Student's Name:	Date of Birth:	Grade:	Teacher:

Medication:	Dosage:	Date:
Time Limit:	Physician's Address:	

_____ _____

PARENT'S SIGNATURE PHYSICIAN SIGNATURE

For the safety of your child, this form MUST BE COMPLETED and RETURNED to the school nurse or administrator by parent or physician. All medications must be in the original container.

PARENT'S - PLEASE KEEP THIS PAGE FOR YOUR RECORDS

DRESS CODE

Rockford School believes that the standards of dress and grooming are primarily the responsibility of the parents and students. Students should wear appropriate school clothing and groom themselves in a manner which reflects credit to themselves, their family and Rockford School. However, under no conditions should clothing or personal grooming be distracting, unsafe, immodest, or disruptive to the education program. When the mode of dress is in question, the school has a responsibility to establish restrictions on student dress or facial adornment. As a result, the following dress code standards have been developed with concern for the safety of the student and the student's ability to participate effectively as a learner.

It should be recognized that styles do change and guidelines will be subject to periodic review. The school also realizes that no set of rules can cover every situation. However, if parents and students will keep in mind such things as neatness, cleanliness, safety, and modesty, a productive educational environment will be established and maintained. Your support as parents will certainly be appreciated in upholding these guidelines.

1. No cut-off jeans.
2. No swim suits or sun suits.
3. No jogging shorts, short shorts or tight-fitting shorts i.e. biker's shorts.
4. No spaghetti straps, tube tops, or halter tops. Sleeveless tops are permissible, but they must be at least 1 ½ inches wide.
5. No backless, strapless or low-cut dresses or tops.
6. No clothing that exposes tummies.
7. No see-through shirts or blouses i.e. fish net.
8. No clothing that has holes, rips, cuts, or tears.
9. No clothing items that advertise drugs, tobacco, alcohol.
10. No clothing items that are considered gang-related i.e. "baggy" clothing too large in width and length.
11. No hats except Rockford School baseball caps or visors or beanies.
12. No undergarments are to be visible at any time.
13. Shorts must be at least 4 ½ inches long from the inseam, and skirts or dresses are not to be shorter than mid thigh.
14. Shirts not tucked in cannot extend below the wrist when the student is standing up straight.
15. Pants must be worn above the hip bone at all times (without the aid of a belt or suspenders).
16. No oversized hanging belts; belts must fit and be fitted through belt loops.
17. No attire that may be used as a weapon is to be worn (i.e. chains, wallet chains, etc.).
18. No clothing that is considered to be distractive to the educational environment of the classroom.
19. Wearing jewelry, rings, studs, etc. as a result of body piercing shall be allowed only in the ear lobe and otherwise shall be considered a distraction to the school climate.
20. Coloring of hair shall be restricted to natural colors and otherwise shall be considered a distraction to the school climate.
21. Consequences for deliberate disregard of the guidelines addressed in the dress code may result in disciplinary action that includes detention, suspension, and/or expulsion.

Rockford School reserves the right to send home any student which, in the opinion of the superintendent and/or staff, is not appropriately dressed for school. If you have any questions regarding the dress code, use this rule of thumb: IF IN DOUBT, DON'T WEAR IT!

State of California—Health and Welfare Agency

Department of Health Services
Child Health and Disability Prevention Program

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

TO PROTECT THE HEALTH OF CHILDREN, CALIFORNIA LAW REQUIRES A HEALTH EXAMINATION ON SCHOOL ENTRY. PLEASE HAVE THIS REPORT FILLED OUT BY A HEALTH EXAMINER AND RETURN IT TO THE SCHOOL—THE SCHOOL WILL KEEP AND MAINTAIN IT AS CONFIDENTIAL INFORMATION.

PART I — TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last	First	Middle	BIRTHDATE—Month/Day/Year

ADDRESS—Number/Street	City	ZIP code	SCHOOL

PART II

HEALTH EXAMINATION Date: _____

Required Tests and Evaluations*	Check When Completed
Health and Developmental History	
Physical Examination	
Nutritional Assessment	
Vision Screening	
Audiometric (hearing) Screening	
Blood Test (for anemia)	
Urine Test	
Tuberculin Test	
Other:	

* All tests and evaluations must be done after the child is 4¼ years of age.

IMMUNIZATION RECORD

Vaccine	Date Each Dose Was Given				
	1st	2nd	3rd	4th	5th
Polio (TOPV/IPV) (circle one)	/ /	/ /	/ /	/ /	/ /
DPT/Td/DT (circle one)	/ /	/ /	/ /	/ /	/ /
Hib	/ /	/ /	/ /	/ /	
Hepatitis B**	/ /	/ /	/ /		
Measles, Mumps, Rubella (MMR)	/ /	/ /			

** Not required for school entry.

Note to Examiner: Please give the family a completed, or updated, yellow California Immunization Record or other personal immunization record.

Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

PART III—ADDITIONAL INFORMATION FROM HEALTH EXAMINER (Optional)

Fill out if patient or guardian has signed release of health information below.

RESULTS AND RECOMMENDATIONS

- ☐ Examination revealed no condition relevant to the school program.
- ☐ Conditions found in the examination or after further evaluation which are of importance to schooling or physical activity are: (please explain)

Name, Address, and Telephone Number of Health Examiner:

➤ _____ _____
Signature of Health Examiner — Date

RELEASE OF HEALTH INFORMATION

I give permission to share the additional results of this examination with the school as stated in Part III.

☐ Please check this box if you do not want the health examiner to fill out Part III.

➤ _____ _____
Signature of Parent or Guardian — Date

If unable to get the examination done, call the Child Health and Disability Prevention Program in your local health department. If you do not want your child to have an examination, you may sign the waiver (PM 171B) form obtained from your child's school.

PM 171A (7/94)

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by October 31 of his/her first year in public school. A California licensed dental professional operating within his scope of practice must perform the check-up and fill out Section 2 of this form. If your child had a dental check-up in the 12 months before he/she started school, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out Section 3.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Sex: ▫ Male ▫ Female
Parent/Guardian Name:	Child's race/ethnicity: ▫ White ▫ Black/African American ▫ Hispanic/Latino ▫ Asian ▫ Native American ▫ Multi-racial ▫ Other_____ ▫ Native Hawaiian/Pacific Islander ▫ Unknown		

Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)

IMPORTANT NOTE: Consider each box separately. Mark each box.

Assessment Date:	Caries Experience (Visible decay and/or fillings present) ▫ Yes ▫ No	Visible Decay Present: ▫ Yes ▫ No	Treatment Urgency: ▫ No obvious problem found ▫ Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) ▫ Urgent care needed (pain, infection, swelling or soft tissue lesions)

_____ _____ _____

Licensed Dental Professional Signature ***CA License Number*** ***Date***

Section 3: Waiver of Oral Health Assessment Requirement

To be filled out by parent or guardian asking to be excused from this requirement

Please excuse my child from the dental check-up because: (Check the box that best describes the reason)

▫ I am unable to find a dental office that will take my child's dental insurance plan.
My child's dental insurance plan is:

▫ Medi-Cal/Denti-Cal ▫ Healthy Families ▫ Healthy Kids ▫ Other _____ ▫ None

▫ I cannot afford a dental check-up for my child.

▫ I do not want my child to receive a dental check-up.

Optional: other reasons my child could not get a dental check-up: _____

If asking to be excused from this requirement: ▶ _____

Signature of parent or guardian ***Date***

The law states schools must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please call your school.

Return this form to the school *no later than* October 31 of your child's first school year.
Original to be kept in child's school record.